		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022418

Facility Name: Regency Healthcare & Rehab Ctr.

Address: 6631 N. Milwaukee (Number) Niles (City) 60714 (Zip Code)

County: Cook

Telephone Number: (847) 647-7444 **Fax #** (847) 588-1330

IDPA ID Number: 362871301002

Date of Initial License for Current Owners: 05/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,299	3,460	9,350	26,109	8
9	SNF/PED					9
10	ICF	35,682	19,846		55,528	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,981	23,306	9,350	81,637	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.35%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/13/76

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/31/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 8,659

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	442,926	42,715	28,896	514,537		514,537		514,537			1
2	Food Purchase		419,946		419,946	(54,168)	365,778	(4,493)	361,285			2
3	Housekeeping	306,743	39,873		346,616		346,616		346,616			3
4	Laundry	100,604	40,902	400	141,906		141,906		141,906			4
5	Heat and Other Utilities			235,543	235,543		235,543	4,028	239,571			5
6	Maintenance	99,006	19,714	76,232	194,952		194,952	296	195,248			6
7	Other (specify):*											7
8	**TOTAL General Services**	949,279	563,150	341,071	1,853,500	(54,168)	1,799,332	(169)	1,799,163			8
	B. Health Care and Programs											
9	Medical Director			32,500	32,500		32,500		32,500			9
10	Nursing and Medical Records	3,628,225	104,403	15,522	3,748,150		3,748,150	(230)	3,747,920			10
10a	Therapy	57,886	247	92	58,225		58,225	1,111	59,336			10a
11	Activities	187,550	7,584	2,048	197,182		197,182		197,182			11
12	Social Services	220,588			220,588		220,588		220,588			12
13	Nurse Aide Training											13
14	Program Transportation							250	250			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,094,249	112,234	50,162	4,256,645		4,256,645	1,131	4,257,776			16
	C. General Administration											
17	Administrative	190,786		394,662	585,448		585,448	(108,108)	477,340			17
18	Directors Fees											18
19	Professional Services			165,719	165,719	(62,611)	103,108	(263)	102,845			19
20	Dues, Fees, Subscriptions & Promotions			135,213	135,213		135,213	(103,365)	31,848			20
21	Clerical & General Office Expenses	290,704	49,158	150,868	490,730		490,730	(104,746)	385,984			21
22	Employee Benefits & Payroll Taxes			1,085,668	1,085,668	54,168	1,139,836		1,139,836			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,804	3,804		3,804		3,804			24
25	Other Admin. Staff Transportation			450	450		450		450			25
26	Insurance-Prop.Liab.Malpractice			321,700	321,700		321,700	6,868	328,568			26
27	Other (specify):*							20,331	20,331			27
28	**TOTAL General Administration**	481,490	49,158	2,258,084	2,788,732	(8,443)	2,780,289	(289,283)	2,491,006			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,525,018	724,542	2,649,317	8,898,877	(62,611)	8,836,266	(288,321)	8,547,945			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. #0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			165,646	165,646		165,646	116,139	281,785			30
31	Amortization of Pre-Op. & Org.			10,704	10,704		10,704	(10,704)				31
32	Interest			74,528	74,528		74,528	349,096	423,624			32
33	Real Estate Taxes			394,813	394,813	62,611	457,424	(20,620)	436,804			33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,080,000)				34
35	Rent-Equipment & Vehicles			27,028	27,028		27,028		27,028			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,752,719	1,752,719	62,611	1,815,330	(646,089)	1,169,241			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	77,775	434,318	187,920	700,013		700,013	(6,157)	693,856			39
40	Barber and Beauty Shops			189	189		189		189			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,700	164,700		164,700		164,700			42
43	Other (specify):*	70,114			70,114		70,114	(70,114)				43
44	**TOTAL Special Cost Centers**	147,889	434,318	352,809	935,016		935,016	(76,271)	858,745			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,672,907	1,158,860	4,754,845	11,586,612		11,586,612	(1,010,681)	10,575,931			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,861)	30		9
10	Interest and Other Investment Income	(3,025)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,193)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,328)	21		24
25	Fund Raising, Advertising and Promotional	(14,361)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,237)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(80,417)	20		28
29	Other-Attach Schedule	(147,550)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (369,072)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(641,609)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (641,609)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,010,681)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Regency Healthcare & Rehab Ctr.

ID# 0022418

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (3,300)	02	1
2	Veterans Expense	(230)	10	2
3	Marketing Salary	(70,114)	43	3
4	Bank Charges	(10,547)	21	4
5	Amortization of Loan Acquisition	(10,704)	31	5
6	COPE Dues	(8,671)	20	6
7	Non-Care Depreciation	(1,775)	30	7
8	Collections	(6,162)	19	8
9	Capitalized R&M	(1,812)	06	9
10	1998 Real Estate Tax Refund	(34,235)	33	10
11				11
12				12
13				13
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98				98
99				99
100				100
101	Total	(147,550)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(4,493)											(4,493)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,594	2,434								4,028	5
6	Maintenance	(1,812)		834	1,274								296	6
7	Other (specify):*													7
8	**TOTAL General Services**	(6,305)		2,428	3,708								(169)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(230)											(230)	10
10a	Therapy				1,111								1,111	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation				250								250	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(230)			1,361								1,131	16
	C. General Administration													
17	Administrative					(108,108)							(108,108)	17
18	Directors Fees													18
19	Professional Services	(6,162)		299	3,359	2,241							(263)	19
20	Fees, Subscriptions & Promotions	(103,549)			95	89							(103,365)	20
21	Clerical & General Office Expenses	(108,112)		16	2,418	932							(104,746)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			535	6,333								6,868	26
27	Other (specify):*					20,331							20,331	27
28	**TOTAL General Administration**	(217,823)		850	12,205	(84,515)							(289,283)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(224,358)		3,278	17,274	(84,515)							(288,321)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(26,636)	134,359	3,358	5,058								116,139	30
31	Amortization of Pre-Op. & Org.	(10,704)											(10,704)	31
32	Interest	(3,025)	342,104	3,807	6,210								349,096	32
33	Real Estate Taxes	(34,235)		5,387	8,228								(20,620)	33
34	Rent-Facility & Grounds		(1,032,000)	(48,000)									(1,080,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(74,600)	(555,537)	(35,448)	19,496								(646,089)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(6,157)								(6,157)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(70,114)											(70,114)	43
44	**TOTAL Special Cost Centers**	(70,114)			(6,157)								(76,271)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(369,072)	(555,537)	(32,170)	30,613	(84,515)							(1,010,681)	45

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Kenneth Nieman	33.34	None		Regency Mgmt.	Niles	Management Co.
Benjamin Rogow	33.33			KNR Partnership	Niles	Building Co.
Lother Kahn	33.33			Regency Rehab	Niles	Therapy Co.
				Regency Building	Niles	Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,032,000	Regency Building	100.00%	$	$ (1,032,000)	1
2	V	32	Interest		Regency Building	100.00%	342,104	342,104	2
3	V	30	Depreciation		Regency Building	100.00%	134,359	134,359	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,032,000			$ 476,463	$ * (555,537)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	KNR ENTERPRISES	100.00%	$ 1,594	$ 1,594	15
16	V	6	REPAIRS AND MAINT.		KNR ENTERPRISES		834	834	16
17	V	19	PROFESSIONAL FEES		KNR ENTERPRISES		299	299	17
18	V	20	DUES AND SUBS.		KNR ENTERPRISES				18
19	V	21	CLERICAL		KNR ENTERPRISES		16	16	19
20	V	26	INSURANCE		KNR ENTERPRISES		535	535	20
21	V	30	DEPRECIATION		KNR ENTERPRISES		3,047	3,047	21
22	V	32	INTEREST EXPENSE		KNR ENTERPRISES		3,807	3,807	22
23	V	33	REAL ESTATE TAXES		KNR ENTERPRISES		5,387	5,387	23
24	V				KNR ENTERPRISES				24
25	V								25
26	V	34	RENT	48,000	KNR ENTERPRISES			(48,000)	26
27	V								27
28	V								28
29	V	30	DEPRECIATION		KNR ENTERPRISES		311	311	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 48,000			$ 15,830	$ * (32,170)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	REGENCY REHABILITATION SERVICES, INC.	100.00%	$ 2,434	$ 2,434	15
16	V	6	REPAIRS AND MAINT.		REGENCY REHABILITATION SERVICES, INC.		1,274	1,274	16
17	V	10	NURSING		REGENCY REHABILITATION SERVICES, INC.				17
18	V	10a	THERAPY CONSULTANTS		REGENCY REHABILITATION SERVICES, INC.		1,111	1,111	18
19	V	14	PROGRAM TRANSPORTATION		REGENCY REHABILITATION SERVICES, INC.		250	250	19
20	V	19	PROFESSIONAL FEES		REGENCY REHABILITATION SERVICES, INC.		3,359	3,359	20
21	V	20	DUES AND SUBS.		REGENCY REHABILITATION SERVICES, INC.		95	95	21
22	V	21	CLERICAL		REGENCY REHABILITATION SERVICES, INC.		2,418	2,418	22
23	V	26	INSURANCE		REGENCY REHABILITATION SERVICES, INC.		6,333	6,333	23
24	V	30	DEPRECIATION		REGENCY REHABILITATION SERVICES, INC.		5,058	5,058	24
25	V	32	INTEREST EXPENSE		REGENCY REHABILITATION SERVICES, INC.		6,210	6,210	25
26	V	33	REAL ESTATE TAXES		REGENCY REHABILITATION SERVICES, INC.		8,228	8,228	26
27	V	39	THERAPY SALARY & BENEFITS		REGENCY REHABILITATION SERVICES, INC.		57,529	57,529	27
28	V								28
29	V								29
30	V								30
31	V	39	PHYSICAL THERAPY	63,686	REGENCY REHABILITATION SERVICES, INC.			(63,686)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 63,686			$ 94,299	$ * 30,613	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		19	PROFESSIONAL FEES	$	REGENCY MANAGEMENT CORP.	100.00%	$ 2,241	$ 2,241	15
16	V		20	DUES, SUBSCRIPTIONS		REGENCY MANAGEMENT CORP.		89	89	16
17	V		21	CLERICAL		REGENCY MANAGEMENT CORP.		932	932	17
18	V									18
19	V		17	MANAGEMENT FEES	394,662	REGENCY MANAGEMENT CORP.			(394,662)	19
20	V									20
21	V									21
22	V		17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		105,750	105,750	22
23	V		27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		7,503	7,503	23
24	V									24
25	V		17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		96,429	96,429	25
26	V		27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		6,842	6,842	26
27	V									27
28	V		17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		84,375	84,375	28
29	V		27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		5,986	5,986	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 394,662			$ 310,147	$ * (84,515)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Kenneth Neiman	Secretary	Administrative	33.34%	None	10.00	25.00%	Mgmt Fee	$ 84,375	17-7	1
2	Benjamin Rogow	President	Administrative	33.33%	None	47.00	78.33%	Mgmt Fee	105,750	17-7	2
3	Lother Kahn	Treasurer	Administrative	33.33%	None	15.00	37.50%	Mgmt Fee	96,429	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 286,554		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: KNR ENTERPRISES
Street Address: 6625 N MILWAKEE
City / State / Zip Code: NILES, IL 60714
Phone Number: ((847) 647 - 1166
Fax Number: ((847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	SQUARE FOOTAGE	6,654	4	$ 17,213	$	616	$ 1,594	1
2	6	REPAIRS AND MAINT.	SQUARE FOOTAGE	6,654	4	9,010		616	834	2
3	19	PROFESSIONAL FEES	SQUARE FOOTAGE	6,654	4	3,225		616	299	3
4	20	DUES AND SUBS.	SQUARE FOOTAGE	6,654	4			616		4
5	21	CLERICAL	SQUARE FOOTAGE	6,654	4	171		616	16	5
6	26	INSURANCE	SQUARE FOOTAGE	6,654	4	5,781		616	535	6
7	30	DEPRECIATION	SQUARE FOOTAGE	6,654	4	32,913		616	3,047	7
8	32	INTEREST EXPENSE	SQUARE FOOTAGE	6,654	4	41,126		616	3,807	8
9	33	REAL ESTATE TAXES	SQUARE FOOTAGE	6,654	4	58,193		616	5,387	9
10										10
11										11
12										12
13										13
14										14
15	30	DEPRECIATION	DIRECT ALLOCATION		4	3,132			311	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 170,764	$		$ 15,830	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REGENCY REHAB SERVICES
Street Address: 6625 N MILWAKEE
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647 - 1116
Fax Number: (847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	THERAPY INCOME	67,083	3	$ 2,564	$	63,686	$ 2,434	1
2	6	REPAIRS AND MAINT.	THERAPY INCOME	67,083	3	1,342		63,686	1,274	2
3	10	NURSING	THERAPY INCOME	67,083	3			63,686		3
4	10a	THERAPY CONSULTANTS	THERAPY INCOME	67,083	3	1,170		63,686	1,111	4
5	14	PROGRAM TRANSPORTATION	THERAPY INCOME	67,083	3	263		63,686	250	5
6	19	PROFESSIONAL FEES	THERAPY INCOME	67,083	3	3,539		63,686	3,359	6
7	20	DUES AND SUBS.	THERAPY INCOME	67,083	3	100		63,686	95	7
8	21	CLERICAL	THERAPY INCOME	67,083	3	2,547		63,686	2,418	8
9	26	INSURANCE	THERAPY INCOME	67,083	3	6,671		63,686	6,333	9
10	30	DEPRECIATION	THERAPY INCOME	67,083	3	5,328		63,686	5,058	10
11	32	INTEREST EXPENSE	THERAPY INCOME	67,083	3	6,542		63,686	6,210	11
12	33	REAL ESTATE TAXES	THERAPY INCOME	67,083	3	8,667		63,686	8,228	12
13	39	THERAPY SALARY & BENEFIT	THERAPY INCOME	67,083	3	60,597	54,344	63,686	57,529	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 99,330	$ 54,344		$ 94,299	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REGENCY MANAGEMENT CORP
Street Address: 6021 N. LAWNDALE
City / State / Zip Code: CHICAGO IL 60659
Phone Number: (847) 647 - 1116
Fax Number: (847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	MNGMNT. FEE INC.	444,662	2	$ 2,525	$	394,662	$ 2,241	1
2	20	DUES, SUBSCRIPTIONS	MNGMNT. FEE INC.	444,662	2	100		394,662	89	2
3	21	CLERICAL	MNGMNT. FEE INC.	444,662	2	1,050		394,662	932	3
4										4
5										5
6										6
7										7
8	17	ADMINISTRATIVE	AVG. HOURS-ROGOW	60	3	135,000	135,000	47	105,750	8
9	27	EMPLOYEE BENEFITS	AVG. HOURS-ROGOW	60	3	9,578		47	7,503	9
10										10
11	17	ADMINISTRATIVE	AVG. HOURS-KAHN	21	3	135,000	135,000	15	96,429	11
12	27	EMPLOYEE BENEFITS	AVG. HOURS-KAHN	21	3	9,578		15	6,842	12
13										13
14	17	ADMINISTRATIVE	AVG. HOURS-NEIMAN	16	3	135,000	135,000	10	84,375	14
15	27	EMPLOYEE BENEFITS	AVG. HOURS-NEIMAN	16	3	9,578		10	5,986	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 437,409	$ 405,000		$ 310,147	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Regency Nursing Venture		X	Second Mortgage	$19,542.00	5/30/81	$ 2,405,912	$ 295,641	5/1/06	7.7300	$ 32,511	1
2	Northern Life Insurance		X	Mortgage	$64,500.00	3/1/95	6,000,000	3,183,539	3/1/10	10.0000	342,104	2
3	Allocate Regency Rehab		X								6,210	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank One		X	Line of Credit				960,000		4.0000	42,017	6
7	Regency at Home Health		X					25,430				7
8	See Supplemental Schedule										3,807	8
9	TOTAL Facility Related				$84,042.00		$ 8,405,912	$ 4,464,610			$ 426,649	9
	B. Non-Facility Related*											
10	Interest Income										(3,025)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (3,025)	14
15	TOTALS (line 9+line14)						$ 8,405,912	$ 4,464,610			$ 423,624	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocate KNR Enterprises		X				$	$			$ 3,807	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,807	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	405,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	438,428	2
3. Under or (over) accrual (line 2 minus line 1).	$	33,428	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	375,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	62,611	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 150,484 For 98-00 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	(34,235)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	436,804	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	386,543	8
	2000	394,231	9
	2001	389,218	10
	2002	394,414	11
	2003	424,813	12

Accrual Decreased Based on Anticipation of Reduction in Assessed Amount

Line 2 Includes an Allocation From KNR Enterprises of $5,387 and from Regency Rehab of $8,228.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Healthcare & Rehab Ctr. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0022418

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31-401-017-0000	Long Term Care Property	$ 4,048.39	$ 4,048.39
2.	10-31-401-018-0000	Long Term Care Property	$ 93,285.60	$ 93,285.60
3.	10-31-401-019-0000	Long Term Care Property	$ 117,112.70	$ 117,112.70
4.	10-31-401-020-0000	Long Term Care Property	$ 117,112.70	$ 117,112.70
5.	10-31-401-021-0000	Long Term Care Property	$ 93,253.43	$ 93,253.43
6.	See Attached	See Attached	$ 58,193.26	$ 13,615.28
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 483,006.08	$ 438,428.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Healthcare & Rehab Ctr. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0022418

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,591 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Regency At-Home Health Services, Ltd. - Home Health Agency - Separate Building
Regency At-Home Care Service, Ltd. - Home Health and Adult Day Care Agency - Separate Building
Regency Rehabilitation Service, Ltd. - Rehabilitation Company - Separate Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		4/30/1981	$ 450,000	1
2					2
3	TOTALS			$ 450,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	2,440		20	-		1,502	9
10	Various			1995	55,899		20	2,796	2,796	26,799	10
11	Various			1996	143,243		20	7,167	7,167	60,351	11
12	Various			1997	109,626		20	5,484	(5,484)	42,031	12
13	Various			1998	546,842		20	27,342	27,342	170,373	13
14	Various			1999	142,449		20	7,123	7,123	39,746	14
15	Various			2000	98,866		20	4,945	4,945	23,740	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		3,708,375	134,359		123,613	(10,746)	1,451,252	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		339,268	8,417		10,830	2,413	104,748	68
69	Financial Statement Depreciation			163,870			(163,870)		69
70	TOTAL (lines 4 thru 69)		$ 5,147,008	$ 306,646		$ 189,300	$ (128,314)	$ 1,920,542	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,147,008	$ 306,646		$ 189,300	$ (117,346)	$ 1,920,542	1
2	Electrical	2001	4,000		20	200	200	800	2
3	Electrical	2001	6,900		20	345	345	1,380	3
4	Emergency Phone	2001	11,500		20	575	575	2,300	4
5	Light Fixtures	2001	3,825		20	191	191	749	5
6	Light Fixtures	2001	3,075		20	154	154	551	6
7	Electrical	2001	4,500		20	225	225	788	7
8	Light Fixtures	2001	2,250		20	113	113	395	8
9	Elec-4Th Flr Fm Rm	2001	5,000		20	250	250	896	9
10	Elec-5Th Flr Fam Rm	2001	5,000		20	250	250	875	10
11	Electrical	2001	1,906		20	95	95	334	11
12	Light Fixtures	2001	2,250		20	113	113	395	12
13	Elec-3Rd Flr Fam Rm	2001	5,000		20	250	250	875	13
14	Asphalt - Park Lot	2001	21,917		20	1,096	1,096	3,836	14
15	Elec-2Nd Flr Fam Rm	2001	5,000		20	250	250	854	15
16	Light Fixt - 2Nd Flr	2001	2,250		20	113	113	385	16
17	Light Fixtures-5Th F	2001	2,250		20	113	113	385	17
18	Elec - 1St Flr Fam F	2001	5,000		20	250	250	854	18
19	Flooring	2001	1,567		20	78	78	268	19
20	Interior Glass	2001	6,982		20	349	349	1,163	20
21	Light Fixtures	2001	1,495		20	75	75	249	21
22	Radio	2001	1,295		20	65	65	205	22
23	Architect Fees	2001	864		20	43	43	134	23
24	Satellite System	2001	3,790		20	190	190	759	24
25	Satelite System	2001	4,596		20	230	230	900	25
26	Door-Dialysis Room	2002	1,450		20	145	145	435	26
27	Electrical	2002	7,904		20	790	790	2,239	27
28	Plumbing-Dialysis Room	2002	30,850		20	3,085	3,085	8,741	28
29	Circuit Panelboard	2002	23,500		20	2,350	2,350	6,267	29
30	Dialysis Room	2002	10,550		20	1,055	1,055	2,725	30
31	Drapes	2002	5,952		20	595	595	1,290	31
32	Signs	2002	1,190		20	119	119	327	32
33	Wallcovering	2002	682		20	68	68	182	33
34	TOTAL (lines 1 thru 33)		$ 5,341,298	$ 306,646		$ 203,120	$ (103,526)	$ 1,963,078	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,341,298	$ 306,646		$ 203,120	$ (103,526)	$ 1,963,078	1
2	Handsink	2002	594		20	59	59	168	2
3	Fountain	2002	2,965		20	297	297	717	3
4	Pump Installation	2002	2,950		20	295	295	664	4
5	Modulators	2002	1,890		20	189	189	441	5
6	Electrical Fixtures	2002	1,360		20	136	136	283	6
7	Wallpaper	2003	8,519		20	852	852	1,349	7
8	Closed Circuit Tv System	2003	6,860		20	686	686	1,258	8
9	Landscaping	2003	13,320		20	1,332	1,332	2,220	9
10	Leasehold Improvements	2003	4,748		20	475	475	791	10
11	Leasehold Improvements	2003	2,674		20	267	267	423	11
12	Install Delayed Egress System	2003	15,845		20	1,585	1,585	2,377	12
13	Install Door	2003	1,674		20	167	167	223	13
14	Install Keyless Entry System	2003	1,785		20	179	179	238	14
15	Install Keyless Entry System	2003	1,685		20	169	169	197	15
16	Elecrical Improv	2004	15,618		20	781	781	781	16
17	Nurse Call System	2004	18,975		20	633	633	633	17
18	Window Drapes	2004	43,746		20	2,187	2,187	2,187	18
19	Repair Tile	2004	1,812		20	181	181	181	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,488,318	$ 306,646		$ 213,590	$ (93,056)	$ 1,978,209	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1981	$ 3,708,375	$ 134,359		$ 123,613	$ (10,746)	$ 1,451,252	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,708,375	$ 134,359		$ 123,613	$ (10,746)	$ 1,451,252	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	KNR Enterprises			1994	$ 118,831	$ 3,047		$ 3,395	$ 348	$ 34,235	4
5	Regency Rehab			1994	181,491	4,654		5,185	531	52,287	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from KNR Enterprises			1994	2,421	-	20	222	222	2,421	9
10	Allocation from KNR Enterprises			1995	358	-	10	36	36	358	10
11	Allocation from KNR Enterprises			1995	5,490	141	20	275	134	2,611	11
12	Allocation from KNR Enterprises			1996	1,657	-	20	83	(83)	685	12
13	Allocation from KNR Enterprises			1997	97	4	20	5	1	38	13
14	Allocation from KNR Enterprises			1999	1,833	47	20	92	45	505	14
15	Allocation from KNR Enterprises			2000	3,272	84	20	164	80	737	15
16	Allocation from KNR Enterprises			2003	1,369	35	20	68	33	108	16
17											17
18	Allocation from Regency Rehabilitation			1994	3,697	-	20	339	339	3,697	18
19	Allocation from Regency Rehabilitation			1995	547	-	10	54	54	547	19
20	Allocation from Regency Rehabilitation			1995	8,355	215	20	418	203	3,969	20
21	Allocation from Regency Rehabilitation			1996	2,520	-	20	126	126	1,040	21
22	Allocation from Regency Rehabilitation			1997	147	7	20	8	1	57	22
23	Allocation from Regency Rehabilitation			1999	2,787	71	20	140	69	767	23
24	Allocation from Regency Rehabilitation			2000	2,314	59	20	116	57	521	24
25	Allocation from Regency Rehabilitation			2003	2,082	53	20	104	51	165	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 339,268	$ 8,417		$ 10,830	$ 2,247	$ 104,748	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 895,072	$	$ 63,792	$ 63,792	10	$ 640,925	71
72	Current Year Purchases	46,721		4,403	4,403	10	4,403	72
73	Fully Depreciated Assets	534,307				10	534,307	73
74								74
75	TOTALS	$ 1,476,100	$	$ 68,195	$ 68,195		$ 1,179,635	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,414,418	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 306,646	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 281,785	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,861)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,157,844	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BUS - 1995	$ 44,625	$	$ 44,625	86
87	1996 DODGE CARAVAN - 1996	36,356	1,775	20,318	87
88					88
89					89
90					90
91	TOTALS	$ 80,981	$ 1,775	$ 64,943	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 27,028 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 111,400	$		$ 111,400	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			15,541			15,541	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	77,775		60,629			138,404	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				282,784		282,784	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					350	151,534		151,884	13
14	TOTAL			$ 77,775		$ 187,920	$ 434,318		$ 700,013	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. **#** 0022418 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 585	$ 585	1
2	Cash-Patient Deposits	35,907	35,907	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,878,912	1,878,912	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,651	21,651	6
7	Other Prepaid Expenses	1,596	1,596	7
8	Accounts Receivable (owners or related parties)	(8,660)	(8,660)	8
9	Other(specify): See Attached Schedule	292,212	292,212	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,222,203	$ 2,222,203	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		760,000	13
14	Buildings, at Historical Cost		5,240,000	14
15	Leasehold Improvements, at Historical Cost	1,310,248	1,310,248	15
16	Equipment, at Historical Cost	1,598,803	1,598,803	16
17	Accumulated Depreciation (book methods)	(1,868,900)	(3,078,131)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	56,215	56,215	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,096,366	$ 5,887,135	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,318,569	$ 8,109,338	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,673,259	$ 1,673,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,474	40,474	28
29	Short-Term Notes Payable	985,430	985,430	29
30	Accrued Salaries Payable	91,184	91,184	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,751	15,751	31
32	Accrued Real Estate Taxes(Sch.IX-B)	375,000	375,000	32
33	Accrued Interest Payable	26,529	26,529	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,500	7,500	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	440,134	440,134	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,655,261	$ 3,655,261	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	295,641	3,479,180	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 295,641	$ 3,479,180	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,950,902	$ 7,134,441	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (632,333)	$ 974,897	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,318,569	$ 8,109,338	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (364,819)	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (364,813)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	507,780	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(775,300)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (267,520)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (632,333)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,813,410	1
2	Discounts and Allowances for all Levels	(995,067)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,818,343	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	696,228	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 696,228	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	625	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	86,180	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,251	19
20	Radiology and X-Ray		20
21	Other Medical Services	307,938	21
22	Laundry	3,761	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 421,755	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,025	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,025	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	155,041	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 155,041	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,094,392	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,853,500	31
32	Health Care	4,256,645	32
33	General Administration	2,788,732	33
	B. Capital Expense		
34	Ownership	1,752,719	34
	C. Ancillary Expense		
35	Special Cost Centers	770,316	35
36	Provider Participation Fee	164,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,586,612	40
41	**Income before Income Taxes (line 30 minus line 40)****	507,780	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 507,780	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,878	2,220	$ 89,223	$ 40.19	1
2	Assistant Director of Nursing	1,812	1,916	65,983	34.44	2
3	Registered Nurses	53,133	57,690	1,348,781	23.38	3
4	Licensed Practical Nurses	15,696	17,054	358,484	21.02	4
5	Nurse Aides & Orderlies	174,707	186,852	1,765,754	9.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,819	2,057	77,775	37.81	7
8	Rehab/Therapy Aides	4,644	5,154	57,886	11.23	8
9	Activity Director	1,637	1,920	36,348	18.93	9
10	Activity Assistants	13,334	14,734	151,202	10.26	10
11	Social Service Workers	12,725	14,514	220,588	15.20	11
12	Dietician	1,809	2,141	55,686	26.01	12
13	Food Service Supervisor	1,903	2,171	38,205	17.60	13
14	Head Cook	5,496	6,384	83,810	13.13	14
15	Cook Helpers/Assistants	31,679	35,078	265,225	7.56	15
16	Dishwashers					16
17	Maintenance Workers	4,449	4,818	99,006	20.55	17
18	Housekeepers	37,957	42,193	306,743	7.27	18
19	Laundry	14,806	16,310	100,604	6.17	19
20	Administrator	1,759	2,057	143,214	69.62	20
21	Assistant Administrator	1,867	2,185	47,572	21.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,930	18,226	290,704	15.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,876	4,352	70,114	16.11	33
34	TOTAL (lines 1 - 33)	402,916	440,026	$ 5,672,907 *	$ 12.89	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	687	$ 28,896	01-03	35
36	Medical Director	Monthly	32,500	09-03	36
37	Medical Records Consultant	Monthly	6,628	10-03	37
38	Nurse Consultant	166	8,294	10-03	38
39	Pharmacist Consultant	Monthly	600	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	2	92	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	2,048	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	893	$ 79,058		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Hecht	Administrator	0	$ 143,214
Carol Eaton	Asst Admin	0	47,572
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 190,786

B. Administrative - Other

Description	Amount
Regency Management Corp. - Management Fees	$ 394,662
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 394,662

C. Professional Services

Vendor/Payee	Type	Amount
TALX UC Express	Unemployment Consult.	$ 2,801
Stanley, Stanley & Kelly	Collections (Adjusted P.5)	6,162
Purchasing Plus	Purchasing Agent	600
KBC Computer	Computer Consultant	7,206
Richard Peelo	Medicare Cost Report	4,800
HDSI	Data Processing	7,082
Giftrap	Computer Consultant	516
Frost, Ruttenberg & Rothblatt	Accounting	51,120
Iservices.com	Computer Services	503
Winston & Strawn	Legal	8,386
Sugar, Friedberg & Felsenthal	Legal	1,270
See Supplemetal Schedule		75,273
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 165,719

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,977
Unemployment Compensation Insurance	39,138
FICA Taxes	428,217
Employee Health Insurance	440,266
Employee Meals	54,168
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits	250
Pension Expense	65,686
Holiday Expense	6,134
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,139,836

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	772
(Indicate # of checks performed 64)	
ILCLTC Dues	8,429
Dues and Subscriptions	512
Licenses and Fees	11,039
Classified Advertising	10,912
Advertsing & Promotion/Yellow Page	94,778
See Supplemental Schedule	184
Less: Public Relations Expense	( )
Non-allowable advertising	(14,361)
Yellow page advertising	(80,417)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,848

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,804
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,804

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. # 0022418 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr. **#** 0022418 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC - $17,100**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,576** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **164,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **54,168** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100 % Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.